VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 18, 2013

Ms. Wendy Beatty, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201

Provider #: 475027

Dear Ms. Beatty:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **December 13, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 11/27/12 and 12/5/12. The investigation was concluded on 12/13/12 after further offsite review. There were regulatory deficiencies identified.	F 000	**Plan of Correction** **F241** **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #1 and resident #2 both had their clothes changed and there were no negative effects from this alleged deficient practice.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to promote care for 1 of 2 residents in the sample in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The findings include: 1. Per review of the medical record on 11/27/12, Resident #1 was admitted with diagnoses that include mental retardation related to cretinism and severe developmental disability. Per direct observation conducted on 11/27/12 on the 3rd floor at 0900 AM, Resident #1 was observed sitting in wheelchair sleeping, across from the nurses station outside the dining room with dried food particles on his/her blue sweat pants and blue sweatshirt. Per observation at 0949 AM, Resident #1 remained in wheelchair in hallway on the 3rd floor still sleeping and	F 241	**2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents who are dependent on others for their care are at risk **3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;** Staff will be educated regarding dignity and respect as it pertains to soiled clothing especially post meals.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

LNHA | 1.14.13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 continued to have dried food particles on his/her sweatpants and sweatshirt. Per observation at 0955 AM, Resident #1 was removed from in front of the nurses station by a facility aide and taken to Resident #1's bedroom and his/her clothing was changed. Per direct observation conducted on 11/27/12 on the 3rd floor at 1228 PM, Resident #1 was observed in his/her wheelchair in front of the nurses station, outside the dining room with dried food particles on his/her sweat pants and sweat shirt. Per observation there were 2 employees at the nurses station within sight of Resident #1 and several facility staff walking back and forth in front of Resident #1 transporting other residents to and from the dining room. Per review of the medical record on 11/27/12, Resident #1 was noted by Social Services to be non-verbal and that staff should anticipate resident's needs. Per review of the comprehensive care plan of Resident #1, the care plan indicated that Resident #1 is non ambulatory (unable to walk by self), eats meals in the main dining room, is aphasic (unable to speak) and needs assistance from staff to change clothing. Per interview with the Director of Nursing and Assistant Director of Nursing on 11/27/12 at 1235 PM, they confirmed that Resident #1 had dried food particles on Resident #1's clothing and that his/her clothing needed to be changed. The DNS and ADNS indicated that their expectation of staff is that a residents clothing needs to be changed when soiled and that Resident #1 had on soiled clothing that was very obvious and staff should	F 241	**4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Audits for soiled clothing will conducted after meals and intermittently through out all 3 shifts daily x 1 week, then weekly x 4, monthly x 4 with results reported through the QAA committee **5. Dates Corrective Action will be completed:** **Responsible:** ADNS, Nurse Managers and Staff Development Substantial Compliance date: January 23, 2013 F241 POC accepted 1/18/13 MCullihan RN Pmc	

WSB

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F 241	Continued From page 2 have changed his/her clothing. Per direct observation on 12/5/12 at 0741 AM on the 3rd floor, Resident #1 was observed sitting across from the nurses station, outside the dining room. Resident #1 was noted to be wearing gray sweat pants that were wet in the front and what appeared to be food particles on them. It was observed that there was a nurse at a medication cart directly in front of Resident #1 and the DNS was on the unit walking around at 0743 AM. Per observation at 0751 AM, Resident #1 continued to have wet gray sweats on and was approached by the DNS and he/she brought resident into the dining room for breakfast. Per observation at 810 AM, the DNS removed Resident #1 from the dining room and brought down to his/her room to change his/her clothing. Per interview on 12/5/12 at 0815 AM with the DNS, he/she confirmed that Resident #1 had wet sweat pants on from the residents constant drooling. The DNS confirmed that he/she was aware of the wet area when the DNS brought Resident #1 into the dining room for breakfast. The DNS confirmed that Resident #1 not been offered to have his/her clothes changed until 815 AM when the DNS offered to change Resident #1's sweatpants and he/she refused.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide or arrange for services by qualified persons for 2 of 6 residents (Resident #1 and #2) identified in accordance with each resident's written plan of care. The findings include: 1. Per review of the medical record on 11/27/12 Resident #1 was admitted to the facility with diagnoses that include mental retardation related to cretinism and severe developmental disability. Per direct observation on 12/5/12, Resident #1 was in hallway on the 3rd floor at 741 AM in his/her wheelchair across from the nurses station with wet gray sweat pants on and sitting in the wheelchair on top of a rolled up bath sheet. Per review of the medical record on 12/5/12, the Social Services (SS) notes dated 1/26/12 that Resident #1 is non verbal and severely developmentally disabled. The SS documentation indicates that: staff needs to anticipate resident's needs. Per review of the nursing assessment Resident #1 is incontinent of bowel and bladder, he/she is a total assist with toileting, dressing and bathing. Review of the Braden Skin Assessment indicates Resident #1 is at risk for skin breakdown. Per review of the comprehensive care plan for Resident #1, the care plan indicates that Resident #1 is to have a wheelchair cushion as a pressure relieving device in the wheelchair. Per direct observation on 12/5/12 at 841 AM, a facility Licensed Nursing Assistant took Resident #1 to his/her room to toilet Resident #1. During direct	F 282	**Plan of Correction** **F282** **1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #1 and Resident #2 had their wheelchair cushions placed back in their chairs and there was no negative effect noted from this alleged deficient practice. **2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents who have been identified as needing a wheelchair cushion on their care plan are at risk	

W288

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F 282	Continued From page 4 observation on 12/5/12 it was observed that when a facility LNA helped Resident #1 transfer from the wheelchair to the toilet the bath sheet that Resident #1 was sitting on was wet. The LNA confirmed after feeling bath sheet on 12/5/12 at 841 AM that the bath sheet that was underneath the behind of Resident #1 was wet. Its was observed on 12/5/12 that when Resident #1 was done toileting, the LNA transferred Resident #1 back into his/her wheel chair with no pressure relieving cushion on the wheelchair. Per interview with the DNS on 12/5/12. he/she confirmed that the comprehensive care plan indicated that Resident #1 was at risk for skin breakdown and that the comprehensive care plan indicated that Resident #1 was to have a pressure relieving cushion in his/her wheelchair. The DNS confirmed on 12/5/12 at approximately 845 AM, Resident #1 was sitting in his/her wheelchair and there was no pressure relieving cushion in place. 2. Per review of the medical record on 12/5/12, Resident #2 was admitted to the facility with diagnoses that included dementia. Per observation on 12/5/12 at 0901 AM, Resident #2 was observed to be sitting in wheelchair with no pressure relieving cushion. Per direct observation Resident #2 received personal care and toileting from facility LNA's at 0913 AM. Per observation Resident #2 was transferred from the toilet to the Resident #2's wheelchair and there was no pressure relieving cushion in the wheelchair of Resident #2. Per direct observation the pressure relieving cushion was noted to be laying on a straight back chair in the residents	F 282	**3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** Staff will be educated regarding following the care plan with regards to wheelchair cushions. **4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Care plans will be audited to identify those residents who are identified as needing wheelchair cushions. Audits will be done on those residents identified to ascertain compliance with the care plan. Audits for compliance to care plan will be done weekly x4 and monthly x 4 with results reported thru QAA **5. Dates Corrective Action will be completed:** Responsible: ADNS, Nurse Managers and Staff Development Substantial compliance by: January 23, 2013	

W888

F282 POC accepted 1/18/13
M Cullihan RN | PMC

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F 282	Continued From page 5 room. Per review of the bladder assessment dated 11/29/11, indicates that Resident #2 is resistive to bladder retraining and is occasionally incontinent of urine. Per review of the Braden Skin Assessment Resident #2 is at risk for skin breakdown. Per review of the comprehensive care plan titled urinary incontinence last updated 11/1/12, it indicates that Resident #2 is to have a pressure reducing cushion in wheelchair. The comprehensive care plan indicates that Resident #2 is incontinent of urine and occasionally bowel, that Resident #2 needs extensive assist with toileting and transfers. Per interview with one of the facility aides that provided personal care and toileting to Resident #2 at 0901 AM on 12/5/12, they indicated that they know what care to provide to a resident by what the care plan indicates. The aides indicate that they are to read the care plan and get a verbal report from the nurses before care is provided so that the aides know what care to be provided. Per interview with the primary LNA on 12/5/12 he/she indicated that he/she did not read the care plan prior to giving care to Resident #2. Per the LNA's review of the resident care plan he/she confirmed that the care plan indicated that Resident #2 was to have a pressure relieving cushion in the wheelchair. The LNA verbalized he/she did not know that Resident #2 needed a cushion on his/her wheelchair. The LNA verbalized that he/she had worked at the facility for a long time and knew the residents and knew what they needed without looking at the care plan	F 282		

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F 282	Continued From page 6 everyday before care is provided. The LNA also verbalized that he/she worked different units and that is why he/she did not know that Resident #2 needed a wheelchair cushion. Per interview with the DNS on 12/5/12 at approximately 845 AM, he/she confirmed that the comprehensive care plan for Resident #2 indicated that there was to be a pressure reducing cushion on the wheelchair and that the DNS's expectation is that LNA's read the care plan for each resident before care is provided every shift in case there are changes and to know what care is to be given.	F 282		